California Advancing & Innovating Medi-Cal (CalAIM)

Annual Managed Care Plan Open Enrollment

12/3/2019

Annual Enrollment Overview

- Currently, in counties with more than one Medi-Cal managed care plan, enrollees may change their Medi-Cal managed care plan every month. This activity limits the plans' ability to provide adequate and appropriate care coordination to their members.

- An annual Medi-Cal managed care plan open enrollment process would allow enrollees to change their Medi-Cal managed care plan only during a specified open enrollment period, however, exceptions will be allowed based on a consumer-friendly process that recognizes true needs for a change in plan.

Annual Enrollment Overview cont.

- Annual Enrollment:
  - Reduces variation and creates standardization for beneficiaries.
  - Reduces member risk by enhancing patient care management and supports the population health management strategies.
  - Improves quality outcomes by allowing the beneficiary to develop long-lasting, positive relationships with their Medi-Cal MCPs and providers.
  - Increases continuity of care, higher quality of care and better health outcomes.
  - Aligns Medi-Cal enrollment with other line of business processes.

Exception Process

- Consumer-friendly exception process will at a minimum include the following:
  - During the first year of enrollment for a beneficiary newly enrolled in Medi-Cal managed care and whose plan was assigned through the default enrollment process
  - During the first year of enrollment for a newborn that is automatically assigned to their mother's Medi-Cal managed care plan
  - During the first year of enrollment for a beneficiary moving from one county to another, whose plan in the new county was assigned through the default enrollment process
  - An enrollee for whom their primary care provider (includes physician extenders) and/or specialists, has terminated his/her contract with the Medi-Cal managed care plan that they are enrolled in, but that provider is available in the other Medi-Cal managed care plan in the county or another provider that is preferred by the beneficiary is available in a different network than their existing plan for whom their current provider has terminated his/her participation
  - Aging into PACE eligibility

Exception Process cont.

The exception process will also include the following allowances for choosing a Plan outside of the Annual Open Enrollment period for “good cause” as defined in Title 42 C.F.R 438.56(d)(2) defining “cause.”

Examples include, but are not limited to:

- Transgender services not available in network;
- HIV/AIDS services not available in network;
- Lack of access to services covered under the contract; and
- Conditions whose management requires coordination of multiple specialties.

Workgroup Deliverables

Provide recommendations on the following items:

1. Provide Pros and Cons of an Annual Health Plan Enrollment process for Medi-Cal beneficiaries.
2. Define the consumer-friendly exceptions and provide ways on how they will be operationalized.
3. Determine what member health plan open enrollment materials are needed as well as timing and content of the materials.

Annual Enrollment: Next Steps

Submit responses to:

CalAIM@dhcs.ca.gov by December 13, 2019.

Next Workgroup Session for *Population Health Management Strategy and Plan Enrollment* is scheduled on January 7, 2020.

Questions?